TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METROCREST SURGERY CENTER, LP

Respondent Name
SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-16-3370-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was not paid according to the 2016 Texas Ambulatory Surgical Center Fee Schedule. We are disputing the allowed amount of the procedure on the attached claim."

Amount in Dispute: $907.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT code 20680 was paid in accordance with CMS guidelines and policy in effect at the time of DOS. There was no 50% reduction under the Multiple Procedure (MP) discount as Addendum AA indicates the MP discount is not applicable . . . Unlike the previous code, Addendum AA clearly indicates that 64721 is subject to Multiple Procedure discounting . . . MP discount applied as indicated by ANSI reason code 59 listed on the line on the EOR."

Response Submitted by: CorVel on behalf of Service Lloyds Insurance Company

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
February 24, 2016	Ambulatory Surgical Services Procedure Codes: 20680 and 64721	$907.97	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the medical fee guideline for ambulatory surgery centers.
3. Texas Insurance Code §1305.006 establishes insurance carrier liability for certain out-of-network health care.
4. Texas Insurance Code §1305.153 addresses provider reimbursement for services subject to a network contract.

5. Insurance Code §1305.153(c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   Insurance Code §1305.006(3) provides that an insurance carrier that establishes or contracts with a network is liable for "health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103."

   This dispute involves authorized out-of-network services approved by the network in accordance with §1305.006. Accordingly, this request for additional reimbursement is reviewed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adj
   - RD7 – Multiple Procedure/1st Procedure
   - RD8 – Multiple Procedure/2nd Procedure (50%)
   - 59 – Allowance based on Multiple Surgery Guidelines.
   - W3 – Appeal/ Reconsideration.
   - 193 – Original payment decision maintained.

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What is the recommended reimbursement for the disputed health care?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The health care provider performed two surgeries billed under procedure codes 20680 and 64721-RT.

   Per Addendum AA, procedure code 20680 is exempt under the ASC rule from Medicare's multiple procedure discounting policy, while procedure code 64721 is *not* exempt, and therefore subject to multiple procedure discounting.

   The insurance carrier reduced payment by 50% for procedure code 64721 with claim adjustment codes:

   - RD8 – Multiple Procedure/2nd Procedure (50%); and
   - 59 – Allowance based on Multiple Surgery Guidelines.

   28 Texas Administrative Code §134.402(d) requires that for coding, billing, and reporting of facility services, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in the rule.

   The respondent's position statement asserts that:

   CPT code 20680 was paid in accordance with CMS guidelines and policy in effect at the time of DOS. There was no 50% reduction under the Multiple Procedure (MP) discount as Addendum AA indicates the MP discount is not applicable . . . Unlike the previous code, Addendum AA clearly indicates that 64721 is subject to Multiple Procedure discounting.

   The requestor did not present documentation to support or discuss and explain how Medicare payment policies support the request for additional payment.

   Medicare policy regarding multiple procedure discounting is addressed in ***Medicare Claims Processing Manual***, CMS Publication 100-04, Chapter 14 – *Ambulatory Surgical Centers*, §40.5 - Payment for Multiple Procedures, which states that:

   > When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors pay 100 percent of the highest paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session. The

OPPS/ASC final rule for the relevant payment year specifies whether or not a surgical procedure is subject to multiple procedure discounting for that year.

The wording in the Claims Processing Manual allows for two interpretations. The first interpretation is that multiple procedure discounting applies to all codes that are not specifically exempted from the policy per Addendum AA. A second interpretation is that Medicare requires payment reduction only when *multiple* procedures were performed that are subject to the policy.

In this case the ASC performed two procedures, but only one procedure was subject to multiple procedure discounting. The procedure that is exempt is the higher paying procedure (20680) — which would have been paid at 100% under either interpretation. While the lesser paying procedure (64721) is not specifically exempt. So does the policy trigger a payment reduction for the second procedure or not?

To clarify the intent of the policy, we look to the 2016 ASC rule as found in *Federal Register* Volume 80, Number 219, page 70502, which states:

> in Addendum AA, a ''Y'' in the column titled ''Subject to Multiple Procedure Discounting'' indicates that the surgical procedure would be subject to the multiple procedure payment reduction policy. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66829 through 66830), most covered surgical procedures are subject to a 50-percent reduction in the ASC payment for the lower-paying procedure when more than one procedure is performed in a single operative session.

To shed further light on the 2016 ASC rule, we look back to the cited discussion in the 2008 ASC rule as found in Federal Register Volume 72, Number 227, pages 66829 and 66830, which states:

> Under the revised ASC payment system, we discount payment for certain multiple and interrupted procedures performed in ASCs. While most covered surgical procedures are subject to a 50 percent reduction in ASC payment for the lower-paying procedure when more than one procedure is performed in a single operative session, those covered surgical procedures that are exempt from the multiple procedure reduction in ASCs because they are not subject to this reduction under the OPPS, are identified in Addendum AA to this final rule with comment period with an ''N'' in the column labeled ''Subject to multiple procedure discounting.''

Based on the Medicare payment policy, as found in the *Medicare Claims Policy Manual* and as discussed in the 2008 and 2016 ASC rules as published in the *Federal Register*, the preponderance of the evidence supports the insurance carrier's position that a multiple procedure discount is applicable to procedure code 64721. The Division concludes that the insurance carrier's payment reduction reasons are supported.

2. This dispute regards ambulatory surgical services with reimbursement subject to 28 Texas Administrative Code §134.202(f), which requires that the calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 Federal Register, or its successor.

   The following minimal modifications apply:

   (1) Reimbursement for non-device intensive procedures shall be:
   (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent

   Reimbursement is calculated as follows:

   - Procedure code 20680, service date February 24, 2016, has status indicator A2 denoting an ASC procedure reimbursed in accordance with Rule §134.402(f)(1). Per Addendum AA, the payment rate for this procedure is $790.85. This amount is divided in two halves, representing the labor-related and non-labor-related portions of $395.43 each. The labor-related half is geographically adjusted by multiplying it by the annual wage index for this facility's location of 0.9847. The adjusted labor portion is $389.38. This amount is added back to the non-labor half. The sum is the Medicare ASC facility rate of $784.81. This amount multiplied by the Division conversion factor of 235% is $1,844.30. This procedure is not subject to

Medicare's multiple procedure payment reduction policy. This procedure is the highest paying procedure performed this date. The first unit of the highest paying procedure is paid at 100%; all other such services (that are not exempt from multiple procedure discounting) are paid at 50%. The reimbursement for this service is $1,844.30.

- Procedure code 64721, service date February 24, 2016, has status indicator A2 denoting an ASC procedure reimbursed in accordance with Rule §134.402(f)(1). Per Addendum AA, the payment rate for this procedure is $778.70. This amount is divided in two halves, representing the labor-related and non-labor-related portions of $389.35 each. The labor-related half is geographically adjusted by multiplying it by the annual wage index for this facility's location of 0.9847. The adjusted labor portion is $383.39. This amount is added back to the non-labor half. The sum is the Medicare ASC facility rate of $772.74. This amount multiplied by the Division conversion factor of 235% is $1,815.94. This procedure is not the highest paying procedure performed this date. This procedure is subject to Medicare's 50% multiple procedure payment reduction policy. The allowable reimbursement for this service is $907.97.

3. The total allowable reimbursement for the services in dispute is $2,752.27. The insurance carrier has paid $2,752.25. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 26, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.